Mental Health Association of Central Australia
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MHACA

MHACA Referral Form

This document relates to the referral of persons to services and programs of the Mental Health Association of Central Australia (MHACA).

Details of Person being referred

Name: _____ Surname: _____

Skin / other names: _____

Date of birth: / / Male ☐ Female ☐ Other ☐

Nationality: _____ Aboriginal ☐ Torres Strait Islander ☐ Other ☐

Address: _____ Phone no.: _____

_____

Emergency Contact Details

Name: _____ Relationship: _____

Address: _____ Phone no.: _____

_____

Is an Interpreter required? Yes ☐ No ☐ Preferred language: _____

Name of interpreter: _____ Agency: _____

Referral Information

Referred by: _____ Title _____

Service Provider (name of agency): _____

Contact phone no: _____ Date: / /

Email: _____

Other organisations involved in management: _____

_____

Program for referral: _____

Reason for referral: _____

Physical & Mental Health History

Diagnosed mental illness/es:

Current mental health presentation:

CAMHS Case Manager: Psychiatrist:

Medical Practitioner:

Recent hospitalisations (please explain):

Dates:

Prescribed medication:

Allergies:

Pre-existing physical health problems:

Co-existing mental health and drug and alcohol problems *(if applicable):*

Relapse and Risk Indicators

Risk of relapse (please explain):

Self-harm (include results of suicide risk assessment) *if applicable:*

Physical violence / threatening behaviours (harm to others) *if applicable*:

Forensic History

Does the referred person have a criminal record? Yes ☐ No ☐
Types of offences:

Inappropriate sexual behavior: Yes ☐ No ☐ Don't know ☐

Please indicate relevant additional material attached *if available*:

☐ Risk Management Assessment / Plan
☐ Individual Care Plan or similar (last 6 months)
☐ HONO's (CAMHS)
☐ Any recent Occupational /Functional Assessments (last 18 months)

*******Please ensure all sections of this referral are completed to reduce delays in acceptance.***

Declaration

Type of referral / person lodging referral:
☐ Self-Referral ☐ Case Manager ☐ Family Member ☐ Significant Other
☐ Service Provider ☐ Other (*please indicate*):

If referred by a person other than the participant, the participant must sign to acknowledge they are aware of and consent to the referral.

I_____ Consent to this referral being submitted on my behalf.

I_____ Declare that all the information provided in this document is accurate to the best of my knowledge. I have made every reasonable effort to obtain correct information from the participant and other organisations involved.

Signature: _____ Date: / /

Designation: _____

For any further queries please contact MHACA's Day Program Coordinator:
Sharon Harris
14 Lindsey Ave, Alice Springs NT 0871
Ph: (08) 8950 4600 Fax: (08) 8952 1574
mobile: 0475 393 021
email: sharon.harris@mhaca.org.au

OFFICE USE ONLY

Date accepted: / / Referred elsewhere: _____

Appointment date: / / Appointment attended: Yes ☐ No ☐

Further action: _____

Approved by: _____ Coordinator ☐ Program Manager ☐